

Ben

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1. BACKGROUND

Cheshire West and Chester Local Safeguarding Adults Board (The LSAB) has a statutory duty to arrange a Safeguarding Adults Review (SAR) where:

- In line with the Care Act 2014, a Safeguarding Adults Review (SAR) is required when an adult with care and support needs has experienced serious abuse or neglect, and there is reasonable cause for concern about how agencies worked together to safeguard the adult. In this case, the SAR focuses on understanding the circumstances that led to Ben experiencing serious self-neglect, with the aim of identifying learning to strengthen future safeguarding practice, and
- There is reasonable cause for concern about how the LSAB, its members, or others worked together to safeguard the adult.

1.1 A Safeguarding Adults Board (SAB), in this instance Cheshire West and Chester Local Safeguarding Adults Board, has the authority to commission reviews in circumstances where there is potential learning to be derived from how agencies worked together, even if it is inconclusive as to whether, in the case of Ben, significant harm was the result of abuse or neglect. Abuse and neglect also include self-neglect.

1.2 LSAB members are invited to actively participate in and support the review process, with a focus on uncovering valuable insights and opportunities to enhance future safeguarding practices. The Safeguarding Adults Review (SAR) is not about apportioning any blame nor responsibility but about promoting a culture of learning and collaboration. Its aim is to identify areas of strength, good practice that can be shared and/or improvement in how agencies, both individually and collectively, safeguard and support adults with care and support needs who are at risk of abuse and/or neglect, including self-neglect, and who may be unable to protect themselves.

1.3 On 5th June 2025, Cheshire West and Chester Local Authority Adult Social Care submitted a referral for consideration of a Safeguarding Adults Review (SAR) regarding Ben. The referral highlighted a series of concerns regarding how services worked together to support Ben to live safely in the community. The main concerns highlighted within the initial referral include the way in which services respond to adults experiencing hoarding and self-neglect, how services work with people who are alcohol dependent, and how professionals work with the Mental Capacity Act and take account of executive functioning in the context of alcohol dependency.

1.4 Ben was aged forty-eight when he died. Ben had a formal diagnosis of anxiety and depression and was prescribed medication by his GP to help manage and stabilise his mental health. Ben was known to secondary mental health services. Ben had been employed earlier in his life and at this time had a steady relationship which produced two children, a son, and a daughter. Ben's children were adults and lived independently. Ben's son lived in the Cheshire West and Chester area, and Ben reportedly had a good relationship with his son. Ben also had a good relationship with his mother, and they were in semi-regular contact. Ben had been living alone in a privately rented apartment although had recently moved to temporary accommodation at the time of his death. Concerns had been raised regarding the condition of Ben's apartment, some of which were attributable to hoarding and self-neglect. It was noted that the condition of Ben's accommodation constituted a fire hazard, and Ben was known to Cheshire Fire and Rescue Service as a person at heightened risk. Ben was alcohol dependent and mental health professionals felt that Ben might have a diagnosis of alcohol induced psychosis. It was noted that Ben was at greater risk of self-neglect when his alcohol intake increased. Ben had a history of suicidal ideation, and this was exacerbated when he drank to excess. Ben was resourceful and skilled in many areas of his life; he was able to maintain important links with family members and managed his finances independently.

2. ENGAGEMENT, MENTAL CAPACITY, MULTI-AGENCY CASE MANAGEMENT AND ALCOHOL USE DISORDERS

2.1 ENGAGEMENT

The most practical challenge with Ben was that at times he was difficult to engage constructively in interventions. Ben had frequent contacts with some services but would not always follow through on steps that would help him, especially with services in the healthcare system: he failed to attend appointments or discharged himself prematurely from care and support services. This made it difficult to undertake the support that would have been required to reduce Ben's susceptibility to risk and stabilise his situation in terms of physical and mental health and social care.

It is easy to see these engagement challenges as a failure on the part of the individual and an indicator of a lack of need for services. Professionals should consider carefully whether non-engagement is, in reality, an indicator of someone who is struggling and needs more assertive intervention. When services experience difficulty engaging with a person, this might mean that the person is under-represented, and as a result, they might be under-served and seldom heard.

The term 'seldom-heard groups' refers to under-represented people who use or might potentially use health or social care services and who are less likely to be heard by professionals and decision-makers from these services.

These groups used to be described as hard to reach – suggesting that there is something that prevents the person's engagement with services. Seldom heard emphasises the responsibility of agencies to reach out to excluded people, as opposed to the onus being on the person to engage with the agency, ensuring that people have access to health and social care services and that their voices can be heard. The term seldom heard is preferred for those reasons.

Since the SAR in respect of Ben has been undertaken, Cheshire West and Chester Safeguarding Adults Board has produced multi-agency guidance for professionals to understand why people are seldom heard.



UNDERSTANDING
WHY PEOPLE ARE SE

2.2 MENTAL CAPACITY

Ben's care raises questions about the use and impact of the Mental Capacity framework. It was noted within the referral that there were no records of a formal Mental Capacity Assessment being completed by adult social care, although this might have been impacted by the fact that that at times Ben was difficult to engage constructively in interventions.

Within the agency chronologies there were over fifty separate occurrences where Ben had stated that he had suicidal ideation. Agencies tended to give weight to Ben's self-reported refusals to take up offers of referral to support services without further assessment or exploration of Ben's mental capacity and executive functioning. Ben appeared to be making decisions which impacted negatively on his physical and mental health and wellbeing, and which may well have contributed to his death. This must raise questions about whether Ben had the mental capacity to make these decisions. There were four references to Ben 'having full capacity in relation to mental health needs and lifestyle choices' without mental capacity assessments being completed to evidence whether the statement that Ben had 'full capacity' were true.

The condition in which Ben lived for the last months of his life must raise questions about whether he really had the capacity to care for himself and take decisions that maintained his health. Therefore, the question is why Ben's capacity to make decisions about his health and wellbeing were not more actively considered by key

professionals. The answer to this can only be conjecture but the following three key themes may be relevant:

- Professionals placing an emphasis on an individual's "right to make unwise decisions" to a degree which is out of step with the legislation.
- Professionals not considering executive function and executive capacity.
- Professionals not understanding the need to continue to take steps with people who do have capacity but nevertheless make unwise decisions.

2.3 MULTI-AGENCY CASE MANAGEMENT

There was good evidence of multi-agency working, particularly instigated by the local authority's adult social care department and joining up adult social care and mental health services. It was noted that Ben was only known to adult social care for a relatively short period prior to his death which, coupled with challenges with Ben engaging constructively with services would limit the scope for intervention.

There were missed opportunities for agencies who had been working with Ben over a longer period to attempt a joint approach to engagement and it appears that some agencies worked in isolation. There was also evidence that concerns identified by agencies were not routinely shared with other agencies involved in Ben's care.

2.4 ALCOHOL USE DISORDERS

Ben's significant use of alcohol was a common theme throughout agency chronologies and was identified as a concern more than two years prior to Ben's death. In the evidence from Ben's GP, the police and secondary mental health services there are reports of Ben presenting as intoxicated.

Ben was referred to alcohol services, initially by one of the local hospitals in Cheshire which was evidence of good practice. After several attempts, demonstrating tenacity and resilience, alcohol services completed a comprehensive assessment with Ben which included a risk management plan and recovery plan. In the main, Ben engaged well with alcohol services and was able to sustain engagement, arguably better than with any other agency involved in his care.

Notwithstanding, Ben experienced some challenges engaging with alcohol services in the last three months of his life and his referral to the service was closed, in conjunction with the service engagement policy. There was evidence that alcohol services tried extremely hard to support Ben and he successfully completed the abstinence in recovery group programme, after which he was offered and engaged in ongoing recovery support, although his engagement was best described as sporadic.

3. METHODOLOGY

This Safeguarding Adults Review (SAR) has been undertaken using a hybrid methodology, chosen to suit the specific circumstances of Ben's case. The process will include an analysis of agency chronologies, with an emphasis on critical reflection and a chronological analysis of events. This personalised approach ensures that all relevant information is captured from the professionals directly involved in Ben's care while creating space for collaborative reflection and development.

By incorporating these elements, the SAR process not only aims to provide answers and understanding for Ben and those close to them but also seeks to identify systemic barriers and enablers that affect best practice. As highlighted in the first and second national analyses of SARs (Preston-Shoot et al, 2020; 2024), it is crucial to adopt a whole-system understanding when conducting reviews of this nature. The findings from that analysis demonstrates how factors that enable or obstruct good practice often reside within interconnected domains of the system. This means the focus must extend beyond individual actions to consider how organisational structures, policies, and inter-agency collaboration either align to support best practice or, in some cases, create misalignments that weaken it.

In this case, Ben is placed at the heart of the SAR process. The aim is not only to understand the circumstances leading up to and following key incidents but also to explore how the systems designed to support the family have interacted and, at times, failed to do so effectively. This includes the involvement of seven agencies

including statutory partners of Cheshire West and Chester LSAB. Each of these agencies has played a role in Ben's life, and the SAR will explore how well their efforts have been coordinated and aligned with Ben's needs.

The SAR process will focus on identifying the enablers of and barriers to good practice, with the aim of making recommendations for improvement across the wider Cheshire West and Chester safeguarding partnership. By placing Ben at the centre and utilising observations from evidence-based research, this review seeks to provide understanding and action in addition to a plan for system-wide improvements to better support individuals and families in similar circumstances.

4. KEY THEMES

4.1 RESPONSE TO ADULTS EXPERIENCING SELF-NEGLECT AND/OR HOARDING IN THE CONTEXT OF ALCOHOL DEPENDENCY

Drug and alcohol dependency can lead to self-neglect. The definition in the statutory guidance which accompanies the *Care Act 2014* is that self-neglect: *"covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding"*. There is evidence to state that Ben could have been considered to be self-neglecting. Cheshire West and Chester self-neglect policy states the following:

"Self-neglect may arise from an unwillingness, or an inability, to care for oneself – or both. These may be interlinked at the point where unwillingness arises from a care and support need e.g. a mental health problem, or cognitive deficit preventing a person from being able to, or wanting to, clean their home. Compounding factors may include alcohol or drug (illicit or prescribed) dependency / misuse and/or the disorganised and chaotic lifestyle and risk-taking behaviour associated with this."

In the second national review of Safeguarding Adult Reviews, self-neglect was the most common category of abuse of all reviews analysed , featuring in 45% of such reviews.

A North West Ambulance Service welfare concern dated 06/10/2023 and received by the local authority on 07/10/2023 states: *"the crew were called to Ben by his GP following a telephone call between themselves. The GP had noted on GP Connect that the call was made by Ben as he wanted to speak to a friend. The GP attempted to advise Ben he should attend Hospital for mental health support however he declined."*

They acted in his best interests and so an ambulance was requested to carry out further assessment. On crew arrival Ben was adamant that he did not require any help but did allow them into the property for a discussion. Upon entering the property, it was evident that the flat was unliveable and unsafe due to large amounts of black mould on every ceiling and wall. There was also a hole in the living room ceiling. The property was extremely cold however Ben did have the windows open. The crew had to complete their assessment via pen torch as though Ben has electric, he does not want to use it. Ben's bedroom was extremely cluttered and a possible fire risk due to an electric heater and a toaster within a confined area of clutter.

In the North West Ambulance Service referral dated 23/10/2024 including concerns for self-neglect, the referral states *"The property was cluttered, and the crew had to climb over a washing machine to get to Ben and he was sitting on alcohol bottles and piles of rubbish, and he had been incontinent. There was no light in the property, and the crew found it very difficult to get around"*

In a case note dated 11/12/2024 the allocated social worker has recorded that: *"Currently author does not feel that Ben has needs best supported by Adult Social Care, with his primary needs being related to alcohol use, his mental health, and housing. Author will continue involvement around Safeguarding to ensure that Ben receives appropriate support"*

This is contradictory to learning from the national review of Safeguarding Adult Reviews and the work of Preston-Shoot (2021) which emphasises the need for multi-agency approaches. Furthermore, referral to Cheshire West and Chester High-Risk panel does not appear to have been considered, in spite of an increased number of welfare concerns in relation to Ben, his physical and mental wellbeing and home conditions.

It was noted that assessment under the *Care Act 2014* had been considered by the local authority adult social care department and that *Care Act* assessment had been 'paused' as per *Care Act* Statutory Guidance, section 6.25: Interventions to take place around mental health and housing, then *Care Act* Assessment to continue. Unfortunately, Ben died before the *Care Act* assessment was able to be completed.

GOOD PRACTICE

- Recognition of safeguarding and onward referrals by North West Ambulance Service, Cheshire and Wirral Partnership NHS Trust and Adult Social Care.
- Safe and well checks completed by Cheshire Fire and Rescue Service.
- Attempts were made to assist Ben to engage with services, even when he declined assistance.

AREAS REQUIRING IMPROVEMENT

- Assumption that support with self-neglect and/or hoarding is solely the remit of Adult Social Care.
- Lack of professional curiosity.
- Clutter Rating Scale not completed.
- Lack of onward referrals by GPs and health staff.
- Lack of formal Mental Capacity Act assessment.
- Mental Capacity Act assessment did not take executive functioning or the effect of alcohol dependency on decision-making into consideration.
- Police would not undertake welfare checks on some occasions, as Ben did not meet the threshold.

4.2 WORKING WITH ADULTS WHO ARE ‘SELDOM HEARD’

The SAR referral highlighted risks to Ben should he not engage with services and concerns about how services work together with people and families who are hard to engage. Seldom Heard has previously been referred to as non-engagement, which encompasses ‘disguised compliance.’ Disguised compliance does not take account of a person’s history, which may include a history of, and/or responses to trauma; nor does it encompass a strengths-based approach.

When services experience difficulty engaging with a person, this might mean that the person is under-represented, and as a result, they might be under-served and seldom heard.

The term 'seldom-heard groups' refers to under-represented people who use or might potentially use health or social care services and who are less likely to be heard by professionals and decision-makers from these services.

These groups used to be described as hard to reach – suggesting that there is something that prevents the person’s engagement with services. Seldom heard emphasises the responsibility of agencies to reach out to excluded people, as

opposed to the onus being on the person to engage with the agency, ensuring that people have access to health and social care services and that their voices can be heard. The term seldom heard is preferred for those reasons.

It would appear that Ben was an adult at risk under the definition set out in the *Care Act 2014* and had a disability as he was experiencing mental illness for which he was prescribed medication, in addition to presenting with alcohol dependency. Therefore, Ben is an example of a cohort with a protected characteristic under the *Equality Act 2010* which makes him more susceptible to being seldom heard.

GOOD PRACTICE

- Recognition of safeguarding and onward referrals by North West Ambulance Service, Cheshire and Wirral Partnership NHS Trust and Adult Social Care.
- Safe and well checks completed by Cheshire Fire and Rescue Service.
- Attempts were made to assist Ben to engage with services, even when he declined assistance.
- Tenacity of services who refused to 'give up' on Ben, in particular, alcohol services.

4.3 USE AND APPLICATION OF THE MENTAL CAPACITY ACT 2005

Within the SAR referral, Adult Social Care expressed a wish for this review to provide learning to explore executive functioning when assessing mental capacity.

From an analysis of the agency chronologies, there is no clear evidence that practitioners considered other reasons such as the impact of alcohol dependency, or any concerns regarding executive function when considering Ben's capacity to make decisions.

Ben was an individual who would often decline offers of support or disengage from services. Quotes from professionals working with Ben clearly evidence this: "Ben did not want intervention and refused to attend hospital", "Ben did not want to engage in any assessment by mental health services"; "Ben did not want to speak to his

landlord regarding his home conditions” Faced with such attitudes it is easy for workers to assert someone’s “right to make unwise decisions”. However, the Mental Capacity Act does not make a broad statement that people have a right to make unwise decisions. They have that right if they have the mental capacity to make that decision. At times, this important caveat can become lost in professionals’ reasoning.

The report of ‘The 2013 Mental Capacity Act 2005: Post-Legislative Scrutiny’, specifically highlighted the challenges posed by individuals like Ben: *The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases, this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult* (paragraph 105).

This was also highlighted in a thematic review in respect of self-neglect published by Torbay and Devon Safeguarding Adults Board in 2023. Within that review, as a Learning Theme, the executive summary states:

Was mental capacity considered? Mental capacity did not receive adequate attention. In several cases involving high-risk decision-making, no capacity assessments took place, and no attention was paid to the possible loss of executive function, which on the evidence of the individuals’ behaviour (including long-term alcohol use) could well have been a feature. There was an over-reliance on assumptions of capacity and on the concept of lifestyle choice. It appears that staff struggle with application of the Mental Capacity Act 2005 in practice” (3:3)

Even if it was decided that Ben did not lack the capacity to care for himself, professionals may still need to help individuals like Ben make decisions about their care. The MCA Code of Practice repeatedly highlights the need to assist capacitous people with their decision making.

2.11 *There may be cause for concern if somebody:*

- *repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or*

- *makes a particular unwise decision that is obviously irrational or out of character.*

These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation.

GOOD PRACTICE

- Familiar staff consulted with Ben, evidencing practical steps to support individual decision making.
- Ben was consistently communicated with.

AREAS REQUIRING IMPROVEMENT

- Capacity assessments not always undertaken or formally recorded.
- Blanket statements that Ben ‘has full capacity’ and that he was making ‘lifestyle choices’ with no subsequent assessment to back these statements up.
- Not always able to evidence that concerns were escalated.
- Professionals making opinions about the outcome of an individual’s decision-making ability without a formal capacity assessment.

LEARNING AND RECOMMENDATIONS

The following table sets out the key recommendations arising from this Safeguarding Adults Review (SAR). These recommendations are designed to address the systemic issues and practice gaps identified, while also building on the examples of positive practice evidenced throughout the care of Ben. Each recommendation is formulated to promote improvement through an emphasis on practical actions, measurable outcomes, and clear lines of accountability across the multi-agency safeguarding partnership in Cheshire West and Chester. The recommendations align with statutory responsibilities, evidence-based practice, and learning from national SAR findings.

Number	Theme	Recommendation	Action	Measure	Timeframe	Lead Agency
1	Theme 1 Response to adults experiencing hoarding and/or self-neglect	<p>Hoarding disorder is recognised by the NHS as a mental health condition. Hoarding is considered a significant problem if the amount of clutter interferes with everyday living and/or if the hoarded items negatively affect the quality of life of the person or their family, both of which apply in this case.</p> <p>This review has highlighted the importance of the Cheshire West & Chester Hoarding Alliance. Outcomes of the Hoarding Alliance include: -Early intervention, which is responsive, personalised, and respective of the individual. -Building a community of</p>	<p>All agencies to ensure that they are aware of Cheshire West & Chester Hoarding Alliance, operational guidance to support the multi-disciplinary team approach and the LSAB self-neglect policy, procedure, and toolkit.</p> <p>All agencies to demonstrate competence in utilising local guidance, policies, and procedures to support people experiencing hoarding and make necessary referrals to the appropriate forums.</p>	<p>Case audits to evidence referral to Cheshire West & Chester Hoarding Alliance and use of local guidance, policies, and procedures to support and evidence defensible professional decision-making.</p> <p>As the Hoarding Alliance has only recently been established, it would be most beneficial to undertake the case file audits once the Hoarding Alliance has been established</p>	<p>Audit of self-neglect and hoarding cases to be considered by LSAB QA & Performance subgroup.</p> <p>To be added to audit schedule and prioritised in accordance with recommendations from other reviews.</p> <p>It would be most useful to review the impact of the Hoarding Alliance once it has become more established and LSAB self-neglect policy, procedure, and toolkit once the revised policy and procedure has been embedded into practice over a longer period.</p>	<p>All agencies, report to LSAB to monitor.</p> <p>Audit and Annual Review of Cheshire West & Chester Hoarding Alliance to be led by LSAB QA & Performance subgroup.</p>

		practice to support professionals working with people experiencing hoarding.		<p>over a longer period.</p> <p>The LSAB self-neglect policy, procedure and toolkit was revised at the end of August 2025 and published on the SAB website in November 2025. As above, it would be most beneficial to undertake the case file audits once professionals have had greater opportunity to use and apply the revised guidance.</p> <p>Target: 90% of case file audits.</p>	<p>Suggested timescale to begin audit in the third quarter of 2026-27.</p> <p>Consultation with professionals and individuals supported via the Hoarding Alliance. Compare 'before and after' experience to measure impact.</p> <p>Annual review of the Hoarding Alliance and use of LSAB self-neglect policy, procedure, and toolkit to extract any themes, trends, or learning.</p>	
2	Theme 2 Working with adults who are 'seldom heard'	The term 'seldom heard' is used to describe under-represented people	Guidance for professionals to support them when working	To raise awareness of the guidance across all	To be confirmed, to align with the case file audits as part of one	All agencies, report to LSAB to monitor.

		who might use services and who are less likely to be heard by professionals and decision-makers.	with people who are 'seldom heard has been produced as an output of the B Family SAR.'	agencies. For this to form part of a multi-agency skills audit to Adult Social to ascertain professionals' confidence in using the 'seldom heard' guidance and knowledge of how and when to use.	overarching piece of work in order to realise efficiencies and to ensure coordinated focus.	Practice leads to work with LSAB QA & Performance subgroup on skills audit.
3	Theme 3 Use and application of the Mental Capacity Act	<p>This review highlighted inconsistent use and application of the <i>Mental Capacity Act 2005</i> with particular reference to executive functioning and assessing capacity in the context of alcohol dependence disorders.</p> <p>If there are reasons to doubt capacity, then a Mental Capacity Act assessment must</p>	<p>Capacity assessments to be formally recorded.</p> <p>Capacity assessments to be decision specific.</p> <p>Concerns to be escalated, via organisational escalation procedures or under safeguarding.</p>	<p>Capacity assessments to be decision-specific and formally recorded and to include a record of executive capacity.</p> <p>LSAB to be assured regarding improved recording in relation to defensible</p>	<p>To align with recommendations from the Mental Capacity Act audit and B Family SAR.</p> <p>Improved recording in relation to defensible decision making, and record of actions. To be monitored via audit led by practice development leads and</p>	<p>All agencies, report to LSAB to monitor.</p> <p>Local authority MCA/DoLs and practice development leads to link with LSAB.</p> <p>To align with MCA subgroup (currently in development).</p>

		be completed in relation to the decision being considered. Only then can a determination be made regarding the individual's capacity. Assessing professionals must take into account the effect of alcohol dependency on decision-making	<p>Make risk management person-centred. Ask 'what is the person's usual behaviour? And reflect this in the formal assessment of mental capacity.</p> <p>Consideration of the impact of alcohol dependency on executive functioning to be integral to all capacity assessments where alcohol or substance misuse, substance dependency or using substances to excess has been identified.</p>	decision making, and record of actions on a multi-agency basis, with a specific emphasis on cases where the individual has an alcohol, drug, or substance dependency.	<p>MCA/DoLs practice manager. To link with local authority MCA subgroup which is in development at the time that this review report was produced.</p> <p>Assurance in respect of partner agencies to be led by the Safeguarding Adults Board.</p>	
4	Theme 4 Response to adults who	The Cheshire West & Chester Persistent Drinkers Alliance will develop	Cheshire West & Chester Safeguarding Adults Board	Monitor the number of referrals to the Cheshire West	Audit of cases referred to Cheshire West & Chester Change	All agencies, report to LSAB to monitor.

	<p>have alcohol dependency</p>	<p>a multi-agency approach for partners to promote community solutions for individuals who drink to excess. The Alliance approach will provide a reflective space to share concerns and issues relating to Individuals who are persistently drinking alcohol to excess, and where this behaviour is having a significant impact on their mental and physical health.</p> <p>Recommendation that Cheshire West & Chester Safeguarding Adults Board raise awareness of the Cheshire West & Chester Change Resistant Drinkers Alliance and how to refer to all board partners and stakeholders working in the</p>	<p>should ensure that all frontline services are aware of, and are able to use, mechanisms to support dependent drinkers, such as Cheshire West & Chester Change Resistant Drinkers Alliance.</p>	<p>& Chester Change Resistant Drinkers Alliance and outcomes for individuals referred to the Alliance.</p>	<p>Resistant Drinkers Alliance to be considered by LSAB QA & Performance subgroup.</p> <p>To be added to audit schedule and prioritised in accordance with recommendations from other reviews.</p> <p>It would be most useful to review the impact of the Cheshire West & Chester Change Resistant Drinkers Alliance once it has become more established and embedded into practice over a longer period.</p> <p>Suggested timescale to begin audit in the third quarter of 2026-27.</p>	<p>Audit and Annual Review of Cheshire West & Chester Change Resistant Drinkers Alliance to be led by LSAB QA & Performance subgroup.</p>
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		Cheshire West & Chester area.			<p>Consultation with professionals and individuals supported via the Cheshire West & Chester Change Resistant Drinkers Alliance. Compare 'before and after' experience to measure impact.</p> <p>Annual review of the Cheshire West & Chester Change Resistant Drinkers Alliance to extract any themes, trends, or learning.</p>	
5	Theme 5 Overarching theme: Professional curiosity	Professional curiosity, escalation, and challenge needs to be embedded into the frontline and managerial practice of all agencies working with adults at risk in Cheshire West & Chester.	This has been addressed through recommendations from the Mary SAR and B Family SAR, although remains outstanding at the time of writing.	The SAB seek assurance from partner agencies that they have reviewed and revised as appropriate their supervision procedures and monitoring systems to	Aligned with recommendations from the Mary SAR and B Family SAR.	Reviewed November 2025. Progress to be monitored by LSAB.

				reduce the likelihood of future failures to initiate relevant internal and multi -agency procedures as identified in the Mary SAR and B Family SAR.		
6	Theme 6 Overarching theme: effective multi-agency communication	Multi-agency collaboration is key in adult safeguarding but is often impacted by system and communication barriers. Hierarchy of decision makers mean that responsibilities can be 'passed on' and nobody takes ownership.	Use of information sharing agreements to ensure that information is shared in accordance with information governance principles and necessary legislation but to also enable those who need to know to be sighted on information, i.e. when an individual is subject to a safeguarding enquiry or there	Contact lists to be kept up to date and shared across the adult safeguarding partnership. LSAB inbox to be central point for coordination and distribution. Partners to send contact lists to the LSAB inbox in the first week of every month. Information sharing to	Within the next 6 months.	All agencies. Coordinated by LSAB.

			are concerns that the person may be susceptible to abuse or neglect.	include distribution of meeting minutes to partners as appropriate. Exploration of the shared care record (CAM system) which could be used to share information on a multi-agency basis.		
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